Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BASSETT SURGERY CENTER
6211 EDGEMERE SUITE 2
EL PASO TX 79925

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

MAY 21, 2012

MFDR Tracking Number

M4-12-2933-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Medicare geographically adjusted fee for procedure 72100 is $21.95; therefore, the reimbursement should be $51.58 ($21.95 x 235%)."

Amount in Dispute: $55.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Fluoroscopy is more detailed than an x-ray. Both were used for the same purpose:…'under fluoroscopic visualization, the spinal needle was advanced…into the anterior epidural canal. An epiduragram was then done using Isovue dye. The contrast was noted to be in the epidural canal.' The X-ray was then taken to confirm the needle placement near the adjacent nerve root where an injection also was given…'An AP lateral of the lumbar spine was done. The needle was at the L5-S1 level. The contrast was in the epidural space.' These are all included in the spinal injection procedures as they are not for a separate purpose other than to confirm successful accomplishment of the procedure. For ASC, fluoroscopy is included in the facility fee. So, again the Carrier's position is that we do not owe the additional $55.01 that is being requested by Bassett Surgery Center."

Response Submitted By: Chartis Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2011	ASC Services for CPT Code 72100-TC	$55.01	$55.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 150-Payer deems the information submitted does not support this level of service.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - VA13-This procedure is included in another procedure performed on this date.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 72100-TC based upon reason codes "97, 150, Z710 and VA13."

   On the disputed date of service the requestor billed the following CPT codes: 64483-SG, 64450-SG-59, 77003, 99144, J2001, Q9967, 72100-TC, J1030, A4930-SG, A4550-SG, and J2400.

   Per NCCI Edits, CPT code 72100-TC is not a component of another service/procedure billed on this date; therefore, reimbursement is recommended.

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   A review of ADDENDUM AA finds that CPT code 72100-TC is not contained in the list of covered ASC surgical procedures.

   A review of ADDENDUM BB finds that CPT code 72100 is listed and has a payment indicator of "Z3".

   ADDENDUM DD1 defined payment indicator "Z3" as "Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs."

   28 Texas Administrative Code §134.402(h) states "For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided."

   The Division finds that CPT code 72100-TC is not reimbursed in accordance with 28 Texas Administrative Code §134.402(f), because Medicare reimburses this service using the Medicare Professional Fee Schedule for nonfacility practice expenses. Therefore, per 28 Texas Administrative Code §134.402(h), reimbursement for this service shall be made using the Division fee guideline applicable to nonfacility professional services.

   Per 28 Texas Administrative Code §134.203(c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is

$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32."

The total allowable reimbursement for CPT code 72100-TC rendered in EL Paso, TX on the disputed date of service is $60.68. The insurance carrier paid $0.00. The difference between the amount due and the amount paid is $60.68. The requestor is seeking dispute resolution for $55.01. As a result, the amount recommended for additional reimbursement is $55.01.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $55.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $55.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		05/30/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.